TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
James Weiss MD

Respondent Name
LM Insurance Co

MFDR Tracking Number
M4-16-3736-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
August 18, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Service codes and CPT codes are not to be bundled nor compounded and are to be billed and reimbursed separately and independently from one another. You will note in the attached narrative report and testing results all required and billed components were performed and documented appropriately utilizing the above TDI-DWC Fee Guidelines and should not be reduced."

Amount in Dispute: $277.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider billed CPT Code 99204, office or other outpatient visit for the evaluation and management of a new patient, which requires 3 key components; comprehensive history, comprehensive examination, and medical decision making of moderate complexity. CPT Code 99204 was denied per Medicare guidelines. HCPCS Code A4556, electrodes per pair, was denied as supplies are not separately payable per Medicare guidelines."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 11, 2016	99204, A4556	$277.50	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 - X263 – The code billed does not meet the level/description of the procedure, performed/documented.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - W3 – Additional payment made on appeal/reconsideration
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
   - X212 – This procedure is included in another procedure performed on this date
   - X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due

Issues

1. Is the carriers' denial supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requester seeks additional reimbursement in the amount of $277.50 for professional medical services.

   The insurance carrier denied disputed service 99204 with claim adjustment reason code 150-X263 – "The code billed does not meet the level/description of the procedure, performed/documented."

   The disputed professional services are subject to 28 Texas Administrative Code §134.203(b) which states in pertinent part,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

   The submitted code in dispute has a narrative description of 99204 – Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 components: A comprehensive history: A comprehensive examination: Medical decision making of moderate complexity.

   Review of the submitted document titled, "Electromyography (EMG) Report finds the following:

Required Element	Present within Submitted Documentation Findings	Requirement of Code Met
Comprehensive History	History of Present illness – 1 condition Review of systems – Musculoskeletal Past Medical History	No – Report supports Expanded Problem Focused
Comprehensive Examination	Body Areas – Left shoulder, low back	No – Report supports Expanded Problem Focused
Moderate complexity medical	Number of Diagnoses or Treatment options – 1 Amount and/or Complexity of Data Reviewed – 3 (Discussion of test results)	Yes – Report supports

decision making	Risk of Significant Complications, Morbidity, and/or Mortality - Low	moderate complexity

Based on the above, the carrier's denial is supported.

The carrier denied code A4556 as X212 – "This procedure is included in another procedure performed on this date."

Review of Code A4556 status finds "P" or excluded as incident to a physician's service (not separately payable)."

As this service is incident to the Needle EMG/Nerve Conduction Study, the carrier's denial is supported.

2. Pursuant to provisions of Rule 134.203 (b), no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		October 21, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.